

POST-OPERATIVE NURSING—ABDOMINAL SECTION

By CHARLOTTE MANDEVILLE PERRY

Superintendent of Nurses, Faxton Hospital, Utica, N. Y.

THE *bête noire* of the surgeon after operation is the remote effect of the anæsthetic upon the intestines, kidneys, heart and lungs. It is important that the nurse in charge of the case should be efficient—thoroughly acquainted with the nursing detail—intelligent in noting symptoms. The use of nitrous oxide, or of scopolamine previous to the administration of ether does much to prevent these harmful effects, which should be anticipated by starting treatment promptly. Normal salt solution if used freely, is sometimes called for in large amounts, and should be prepared for every laparotomy,—infiltration and infusion sets being in perfect working order and sterile. When absorbed into the system, salt solution restores equilibrium to the circulation, and stimulates the kidneys and the whole system in conditions of shock. It should be kept at a temperature of 112° F. for flushing out the abdominal cavity; for controlling hemorrhage, about 114° F.

The nurse's responsibility begins at the time the patient is entrusted to her by the surgeon. When necessary, warmed blankets may be brought into the operating room to avoid chilling the patient while being transferred to a bed which has been previously heated. The first twenty-four or forty-eight hours is a time of anxiety to the nurse and a test to the patient's resistive power. Before distension begins, stimulating enemata of eight ounces of normal salt solution, at a temperature of 110° F., may be given to increase the amount of urine. Skill in giving enemata is proof of a nurse's capability. The rectal tube should be inserted eight or more inches, and carried beyond the sigmoid flexure—the proper direction and force being exerted. Sometimes this may be successfully accomplished by floating the tube over a current of salt solution which is allowed to escape in the rectum while it is being passed. The same precaution against exposing the patient to cold is to be observed, especially when nephritis is likely to be present. Distension is to be expected and dealt with promptly. To relieve this condition, enemata containing ox-gall, asafoetida or turpentine, combined with glycerine one ounce and saturated solution of magnesium sulphate four ounces are ordered; also, eserine, hypodermatically. This acts as a relaxant upon the intestinal wall. Objections to morphia are partly overcome by combining it with

atropine, which is occasionally used instead of eserine. There are two points to remember in the administration of enemata to relieve distension. One is to begin early before the accumulation of gas in the lower bowel drives back the injected fluid. The other most important thing is to see that the enemata are returned, with or without result—thus avoiding intestinal drownage and further paralysis of the wall. Persistence, as well as watchfulness, is needed in treating distension. The successful passing of the rectal tube often results in the expulsion of flatus, which is the object desired. Calomel and salts may be begun after nausea ceases; the salts often will be retained when given hot, in divided doses. Plenty of distilled water by mouth and concentrated nourishment, as the condition permits, will be so much gained for the patient.

For nephritic patients, the hot air, vapor or steam bath will be in order; also, the hot, wet or dry pack. Worse than none is the imperfect construction or application of one or the other. For the hot air bath, the alcohol lamp is better, as it generates more heat. An elbow pipe covered with asbestos, cradles, three long rubber sheets, and an atmospheric thermometer registering from 150° to 200° F. will be needed. A rubber lining to the hot air chamber is preferable to blankets, which absorb the heat and moisture. These may be used as additional cover to the cradles, thus conserving heat. The patient lies on a long rubber sheet, loosely enveloped in a light woolen blanket. It must be noted that moist heat is more penetrating than dry. To aid in diaphoresis, pilocarpine may be prescribed, as in cases of uremia or eclampsia.

During the first two or three days, the temperature may not be significant. It becomes noteworthy, if complications arise, such as pneumonia, when the respirations will be increased; or, a subnormal temperature may indicate a state of collapse. The value of a record of the temperature, pulse and respiration lies in its showing, perhaps, the absence of such complications. But in reporting to the surgeon, the actual salient points of the patient's condition should be mentioned, not those which at the time are insignificant. The character and rate of the pulse; whether or not there is distension; the amount of urine obtained after eight hours have elapsed since the operation; these are the first things to be observed. The attention must be centered upon the abdominal condition, though it may be arrested by any signs of disorder. The heart action must be watched continually; it is a great guide. For stimulation, strychnia acts upon the cardiac muscle; aseptic ergot does more through its power over the vaso-constrictor nerve. Adrenalin chloride also increases the tension of the pulse and results are obtained quickly from its use.

Classifying operations as septic or clean, the more septic a case, the more thorough should be the drainage. The patient should be kept strictly on his side to secure the benefit of gravity. A nurse is often left with the dressing of such a wound, and should manifest no timidity in getting at the bottom of a sinus. Nourishing diet is an important factor whenever the system has become depleted through sepsis. In clean cases, there is a certain relief in knowing the wound is closed and in the hope of its healing by first intention. Yet, even here, there are enemies in ambush, *e.g.*, internal hemorrhage. There may be a slow oozing which fills the abdominal cavity, closely resembling distension, the symptoms of which may be mistaken for shock from other causes. The mind, therefore, should habitually review all the possible avenues of danger and be prepared for the unexpected, the one thing which happens. Embolism is another dreaded foe. Those who have nursed to convalescence only to lose a patient in less than ten minutes know some of the disappointments of professional service. It is a cause for thankfulness that these accidents are of rare occurrence, and that the efficient nurse may so frequently find her joy in bringing the surgeon's work to a successful termination.

NURSING YOUNG CHILDREN

By ANNA J. HASWELL

Graduate Illinois Training School for Nurses

THE nursing of young children stands out as a division of our work needing special study. We have no branch that is more important. When a nurse enters a home to care for a sick child she is given a great responsibility, and if she is fitted to do the work she must have had preparation for it.

Children are so at our mercy; no nurse can have the right spirit and not show great kindness to them. They must see that we are their friends and there to help them. It is not strange that a child who has always been cared for by parents or some one else in the home naturally shrinks from a stranger, and we often have to win our way and sometimes let the mother do things we would otherwise do until the child becomes accustomed to us. Kindness must include firmness. This is very important. We should avoid making a child cry as that is very apt to make him worse, particularly if the disease involves the throat or lungs, but with tact the medicines will be taken and treatments given.

Do not try to deceive a child. If he finds that we have led him